

## The Business of Hospital Charge Capture

Like most businesses, hospitals must be able to catalog, appropriately charge, and reconcile all services provided to its customers. In a hospital's case, however, the patient is the "customer" and each patient that passes through the doors of a hospital will experience a different encounter. Imagine the monumental task of making sure that each patient is charged comprehensively and compliantly for all services rendered and supplies and pharmaceuticals used. In a hospital, this task is monumental in that it is also further complicated by the fact that each patient may have unique insurance coverage and billing requirements that make the seemingly straightforward, but yet time consuming, act of patient charge capture an intricate and inefficient event which often leads to lost revenue. Patient charge capture in a hospital setting consists of complex and disjointed systems, operational activities, and clinical processes.

Relative to these complexities, the hospital charge capture process is often difficult and subject to a variety of breakdowns. After patient services are rendered, it is commonly the responsibility of clinical staff to precisely document the five Ws: "who", "what", "when", "where", and "why" of that patient encounter and then accurately translate the complete patient encounter to charges. While it is often clinically clear what patient services have been rendered, specific payer billing requirements and government regulation frequently drive "how" services should be documented in the patient record and subsequently reported on the patient bill (claim) in order to be paid. The ability to satisfy payer documentation and coding requirements necessary to receive appropriate payment is difficult to administer. It is these intricacies related to charge capture and billing processes that create a plethora of opportunities for breakdowns in the revenue cycle which often result in the loss of reimbursement.

This document specifically addresses some of the common contributing factors for lost charges in the middle revenue cycle and how some organizations are mitigating this risk.

### Managing the Hospital Charge Description Master (CDM)

#### **Periodic review of a hospital's CDM can often reveal breakdowns.**

The accuracy of a hospital's CDM can often reveal breakdowns in the charge capture process. Although not the primary focus of this discussion, the hospital CDM contributes greatly to the middle revenue cycle. Issues frequently identified through review of a hospital CDM include:

- **Reimbursable services reflected in the hospital CDM as "no-charge" or "statistical":** This is often not the result of a conscious decision but one of unfamiliarity with regulatory policies surrounding chargeability of services and being unaware of how other organizations in the surrounding area or across the nation are charging. Hospital organizations may yield to compliance caution if the chargeability of a service is not well understood.

- **Inaccurate charge descriptions for services or supplies in the CDM:** The appropriate coding of certain CDM items may change over time and charge descriptions for that item may not be updated accordingly. Typically, when a line item already exists in the CDM, it is the responsibility of the “Revenue Management”, “Revenue Integrity,”, “CDM”- charge description master (or equivalent) group to make timely changes. When the description of the service, supply or pharmaceutical is not accurately maintained, new or changing CPT/HCPCS codes may not be applied. Narrative descriptions of charge items should be reviewed periodically to ensure they accurately describe the service being delivered. In addition, pricing transparency mandated by regulatory bodies is focusing on patient interpretation of services. CDM descriptions should be clear from both a clinical as well as patient perspective.
- **CPT or HCPCS and/or revenue codes have been inaccurately assigned:** Improper code assignments can result in inappropriate payment or payer denials.
- **Inconsistent pricing across departments for similar services:** While there may be reasons for pricing differences for similarly coded services across departments of an organization, payers have taken note of this and in some cases are pursuing audit of these services.
- **Obsolete charges are in the CDM:** Obsolete or invalid charge items impacts both the inaccuracy and size of the CDM. These lines often contribute to manual business office manipulation of any claim that contains an obsolete charge.
- **Miscellaneous Charge Codes:** Miscellaneous charge codes are often used in the CDM for infrequently provided services. Miscellaneous charge codes leads to ineffective charge capture for a variety of situations:
  - *Specific services, supplies or pharmaceuticals entered under this catch all charge code are not monitored:* When a service is provided multiple times, a new CDM line should be created for that specific service. A department will achieve greater compliance for comprehensive charging when a specific charge already exists in the CDM.
  - *The department is unaware of payer documentation, billing and reimbursement requirements for miscellaneous services rendered:* Because clinical staff are responsible for documenting and charging appropriately, hospitals often rely on their ability to keep up with the latest payer guidelines. The clinical staff’s primary responsibility is taking care of the patient. While that role is certainly expanding to include becoming more knowledgeable with third-party payer requirement documentation, billing regulation and reimbursement knowledge, it is still in the early stages.
- **Active CDM lines that are not used:** CDM lines should be reviewed on a regular basis to make sure that the service, supply or pharmaceutical that it represents is still valid and appropriate.
- **Inappropriate CDM pricing:** While pricing that is too low can result in less than optimal reimbursement, pricing that is too high may be challenged by some payers.
- **CDM allows for a pricing override:** Lines that allow for pricing overrides (for example, those leveraged by clinical departments such as the Operating Room) should be closely monitored. Many times, these items are associated with very high cost devices or

supplies. It is often recommended that these high cost device or supplies be represented separately in the CDM. Special consideration should be allotted to the revenue code assignment of these “carve-out” lines. Reimbursement for some third-party payers can be driven off of revenue code assignment (e.g. a payer contractual carve-out may be negotiated for additional payment for revenue code 278, implantable device versus revenue code 272 (sterile supply).

- **Inconsistent formulas for central supply or pharmaceutical pricing:** Often the mark-up formulas or system unit conversions for supplies and pharmaceuticals is not reviewed for a substantial time period and/or prices are simply adjusted over time by a standard percentage increase, which changes the formula logic. Special attention to hospital formularies and mark-ups is essential to maintaining appropriate CDM pricing.
- **Mismanagement of time-base charge methodologies:** Time-based charge methodologies related to HIM driven coding on final bills are often misunderstood by hospitals. Too often, a total dollar amount driven from time-based charging in clinical areas such as Surgery, for example, results in one charge line on the bill prior to coding. If a coder, for example, assigns multiple CPT or HCPCS codes to that single line, the dollars are often distributed across these CPT or HCPCS codes, resulting in a lower cumulative dollar amount per service amount. This can be especially detrimental in situations where payers are payers reimburse a lesser amount of negotiated fee schedule if the hospital charge is below the contracted rate.

### **Administration of the Charge Capture Process**

The CDM is undisputedly an integral component of the middle revenue cycle, but it is by no means the most important in the process. It is paramount to keep in mind that while a hospital can boast a robust and accurate CDM, interpreting and applying the CDM for day-to-day patient charging is a completely different story. In regard to this, it is pertinent to understand that a complete and accurate CDM is hospital-specific, while a complete and accurate charge capture process is patient specific.

During a single patient visit, many different hospital departments and associated personnel within those departments contribute to providing and charging for the appropriate services, supplies and pharmaceuticals that contribute to a common patient system encounter. Possible disparities associated with multiple ancillary system communication interfaces within the hospital financial system, can contribute to erroneous charging practices.

Accurate clinical charge capture also relies on nursing, ancillary, and other support staff to understand governmental charge capture and coding regulations, payer charging and billing nuances, and mandated procedural documentation guidelines in addition to providing quality medical care. These factors can make the process of capturing charges for these activities complex and ponderous.

Typical charge capture breakdowns include the following:

- **A CDM line representing the service rendered is not available to the staff:** A CDM charge code representing a chargeable service is not on the hospital CDM. This could prevent the clinical area from charging for the service rendered to the patient or it could encourage the clinical staff to charge for the service utilizing the miscellaneous CDM line. Utilizing this miscellaneous charge code could lead to a misrepresentation of services rendered.
- **Clinical staff is not capturing all appropriate charges:** The charges for all services, supplies and pharmaceuticals rendered to the patient are available to the clinical staff but are not charged:
  - Misunderstanding of chargeable versus non-chargeable services.
  - Conscious decision by personnel to not charge for the service.
  - Misinterpretation of hospital charge capture policy or inappropriate knowledge transfer of hospital charge capture policy for new clinical or supportive staff.
  - Inconsistent charge capture procedures between departments due to training constraints
- **System Limitations:** Many times order and charge profiles are not constructed to support charging for some procedures and services:
  - Systems are not maintained and updated with the latest and most comprehensive billing and reimbursement guidelines.
  - Automated order-entry or charge-capture system is not monitored with regular frequency to catch interface data transfer discrepancies and interface failures. The implementation of any automated system should trigger a significant evaluation of charge practices prior to roll-out and provide an opportunity to establish policies surrounding maintenance, automated support and controls without unreasonable effort.
- **Poorly documented department reconciliation processes:** Many hospital organizations establish policy and procedure surrounding departmental charge reconciliation. Often, daily charge reconciliation is mandated. The process of reconciling daily charges is often manual and burdensome, requiring a cross-referencing of daily scheduled visits to appropriate documentation. Industry-standard practice dictate reconciliation by exception for those patient encounters with missing or inaccurate charging.
- **Inadequate monitoring of daily department revenues:** National leading practice guidelines suggest that the benchmarking and monitoring of daily department revenue decreases the frequency of patient overcharges. These overcharges could result from key stroke errors. In addition to this, revenue delay associated with interface failures may often result in undercharges. By prospectively alerting clinical or revenue management staff to these aberrances early, the hospital is able to correct the problem before it shifts further down stream in the revenue cycle. By early detection of these aberrance and prospectively alerting clinical and revenue management staff, the hospital is able to correct the problem before it shifts further down stream in the revenue cycle.
- **Insufficient or ineffective charge capture tools:** Frequently, charge sheets or other approaches to capturing charges, such as system templates or mapping charges to

electronic documentation are misinterpreted by clinical staff. The charge capture vehicle may be too complicated, or may not mirror the current CDM. This may lead to inaccurate or inappropriate charging and may not be included in the permanent health record.

- **Overall delayed or lost charges:** This could be the result of:
  - Insufficient documentation according to established payer guidelines.
  - Unmonitored bridge routine between the claim scrubber and the established financial system.
  - Miscommunication between any established health information and billing system which can result in an inappropriate, incomprehensive or late charge.
  - Charge was simply never entered or recorded
- **Lack of prospective management of National Correct Coding Initiative Edits (NCCI):** As a patient visit often includes services from various clinical departments (i.e. Emergency Department, Lab, Radiology, etc.), charges driven from these areas can often conflict. Modifiers are often introduced to the patient bill to distinguish the services rendered by each department. Because this is such a complicated, but common problem in the charge capture process, the following scenario is included to illustrate a common point:
  - *SCENARIO:* A patient presenting for a head ache in the Emergency Department. The patient will be processed through the Emergency Department (ED) for evaluation and management where they might receive an injection for pain or nausea. They then proceed to the Radiology for a Computed Axial Scan (CT) scan of the head with contrast media. In this case, the injection provided in the ED would need a modifier to distinguish it from the injection of contrast media in CT. If NCCI requirements can be addressed at the clinical level, the volume of claims reviewed by billing staff can be reduced, resulting in a more efficient billing process and quicker claim turn-around.

Recent industry changes within the Medicare program, such as MAC (Medicare Administrative Contractors) and RAC (Recovery Audit Contractors) as well as payment rate cuts to hospitals in 2010 are ever suggestive that accurate charge capture for hospitals has never played a more important financial role. Reimbursement for both inpatient and outpatient services is evolving. This can be attributed to a hodge-podge reimbursement methodology often associated with contractual percentage of charges, APC payment methodology, or occasionally a stop-loss provision of total charges on the inpatient bill based on total charges.

In addition to this, accurate and timely capture of charges enables more efficient billing of services and collecting of associated reimbursement and improves net collections and cash flow. With an efficient charge capture process, bills do not have to be held for late or inaccurate charges, and accounts will not have duplicative services within a patient encounter. As a result, research efforts generally decrease as questions related to duplicate charges, charge codes, and so forth are reduced. Proactively addressing appropriate and comprehensive charge capture early on in the hospital revenue cycle has its benefits.

## What are hospitals doing to address this issue?

Observation of national leading practice guidelines in the revenue cycle specifically related to maintenance of the hospital CDM and charge capture processes demonstrates that many hospitals have implemented teams of individuals to support operational charge capture issues. For purposes of this discussion, management of the middle revenue cycle, maintenance of the hospital CDM and charge capture process as well as related activities, is segregated into two approaches: the centralized approach and the decentralized approach.

### Centralized Middle Revenue Management Approach

The centralized middle revenue cycle model typically consists of a charge capture team that supports several facets of the middle revenue cycle. It leverages a Revenue Management department or team of individuals whose responsibilities include but may not be limited to:

- Management of the hospital CDM
- Oversight of the clinical charge capture process to include clinical training
- Retrospective audit and clinical and/or coding process improvement
- Participation in denial management activities and contract negotiations
- Participation in or Leadership of Revenue Integrity Steering Committees
- Evaluation of new service lines related to reimbursement valuation
- Monitoring of daily department revenues and late charges
- Patient-initiated price estimates

Leading practice suggests that management of this centralized model typically resides within the Finance Department (or related area such as the Business Office or Corporate Compliance) of the organization and ultimately reporting to senior administration such as a CFO. With direction or management outside of the clinical operations facet, this model allows for autonomy of those individuals managing the charge capture process without the expectation of clinical participation. An example of this type of resource might be that of the Charge Analyst.

The Charge Analyst has charge capture responsibility to the clinical department but reports upwards through the Finance Department. The activities of this position could include:

- **Charge posting and reconciliation:** The Charge Analyst may be tasked with the responsibility of charging for all services rendered within a clinical department or may only perform daily charge reconciliation procedures for that department. The effectiveness of daily charging or charge reconciliation is greatly enhanced by the utilization of charge capture software technology. This technology allows Charge Analysts to easily pinpoint missing charges and identify whether any non-compliant charging practice exist. Typically, these technologies allow the hospital to customize

according to specific payer requirements. On average, a hospital can appreciate between as little as 1 up to 7% of bottom line net revenue by utilizing a technology.

- **Documentation validation and clinical staff education:** As the Charge Analyst reviews documentation relative to charges posted, real-time feedback to clinical staff and verification or correction of documentation can be explored. Also in this scenario, progressive charge capture counseling and staff education regarding appropriate and comprehensive documentation is much more easily facilitated.
- **Management of Daily Revenue:** By leveraging historical information, the Charge Analyst can assist in finding missing or inappropriate charging by analyzing daily revenue trending and benchmark variance data. This allows the clinical area to find charge errors related to key stroke errors, interface errors, or any variety of contributing factors.

By instituting this position in high volume outpatient clinical departments, the hospital can appreciate improvement in overall charge capture, clinical documentation enhancement, and reduction in back-end claim manipulation. Real-time feedback to clinical staff will allow for generation of a clean, compliant and comprehensive claim the first time. This will ultimately increase cash flow and generate increased bottom-line revenue. A sense of accountability for appropriate charging will likely emerge from the clinical staff. In addition, by employing the use of technology to the daily charging practice, Charge Analysts are now able to more effectively train and educate clinical staff while generating significant revenue for the clinical department and hospital.

Oversight of the Charge Analyst, especially in a multi-hospital organization, could also involve a Clinical Liaison. An example of the Clinical Liaison position might be a MBA-prepared individual with a clinical background, such as Registered Nurse, Radiology Technologist, Medical Laboratory Technologist, or person holding an equivalent clinical license. The responsibilities of the Clinical Liaison would be to provide oversight and clinical knowledge transfer to Charge Analysts allocated to specific clinical departments. This position would also have direct reporting to the Director of Revenue Management, who then in turn reports upward to the Chief Financial Officer (CFO) (Figure 1).

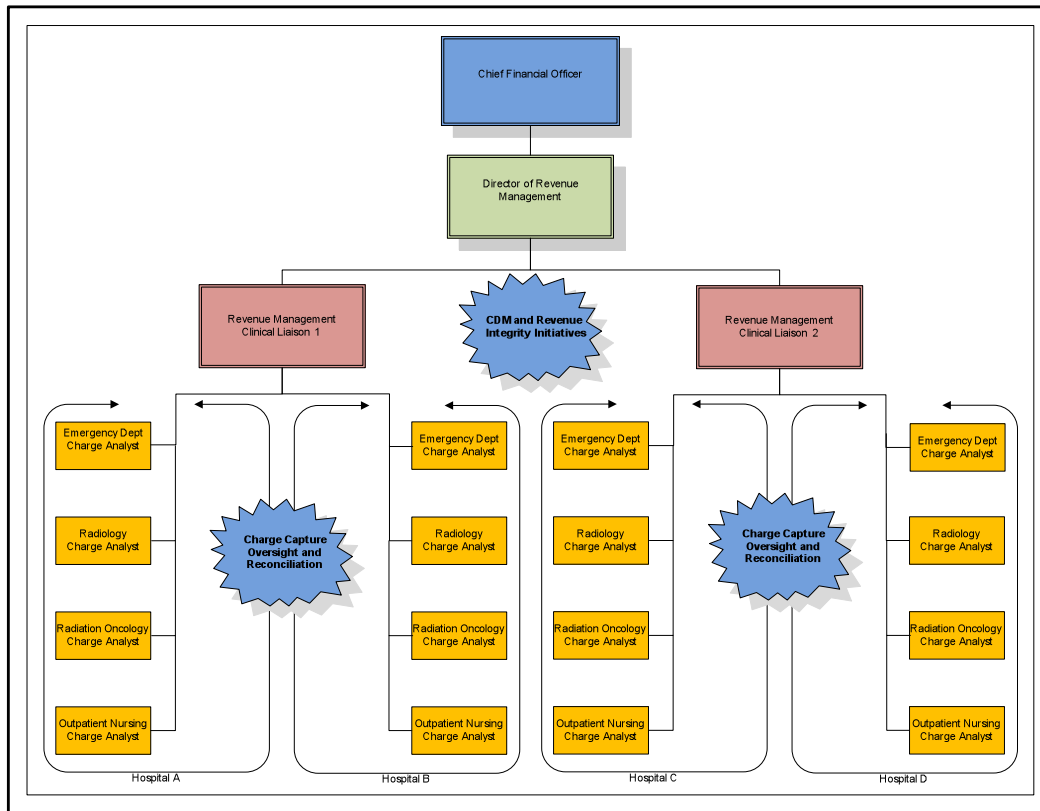


Figure 1

## Decentralized Middle Revenue Management Approach

The decentralized model depends heavily on clinical department operations to accomplish efficient patient charge capture. The clinical staff, more than likely, is responsible for most aspects of the charge capture process including both charging and reconciling those daily charges. This approach places the bulk of daily revenue generation for any given department on patient care staff, who may not always understand governmental, or Fiscal Intermediary rules, regulations, or documentation guidelines regarding charging. A decentralized model typically has the following characteristics:

- Clinical staff is responsible for daily revenue capture and charge reconciliation procedures
- Clinical staff is responsible CDM maintenance on codes that apply to their department
- The CDM department is typically used by the clinical staff as a support function for charge capture, compliance and CDM questions but usually do not participate in day-to-day charging oversight
- The CDM department may or may not have specific people dedicated to specific clinical departments
- Any coordination for manual charge sheets or automated charge screen changes is the responsibility of the clinical department



- The use of technology to support the clinicians in daily charge capture is typically not seen

The realities of a decentralized charge capture model include:

- **Clinical staff must focus on providing patient care and understand billing, compliance and coding regulations:** Clinical personnel may not understand the revenue aspect of patient care (payer guidelines, Medicare National Correct Coding Initiative, payment methodologies, etc). It is often noted that patient care personnel view the intricacies of charge capture as the responsibility of another support department, such as the Central Business Office. Many see the charge capture process as cumbersome and complicated; ultimately, secondary to their responsibility as care givers.
- **Daily charge reconciliation is often delayed or not performed at all:** When the responsibility for patient care, appropriate charge capture and daily charge reconciliation procedures fall to the clinical staff with little support, responsibilities may not always be fulfilled. Often, daily charge reconciliation is the first to be cut. Many clinical areas do not perform charge reconciliation, a very important exercise and crucial to compliant charge capture.
- **Insufficient support structure to realize all appropriate revenues within each clinical area:** When the CDM department is not only responsible for the day-to-day maintenance of the CDM, but also serving as a support structure for compliance and charge capture functions, a bottleneck is likely to exist. Clinical areas may find it difficult to glean the support needed to efficiently support their CDM and manage the charge capture process. (Figure 2)

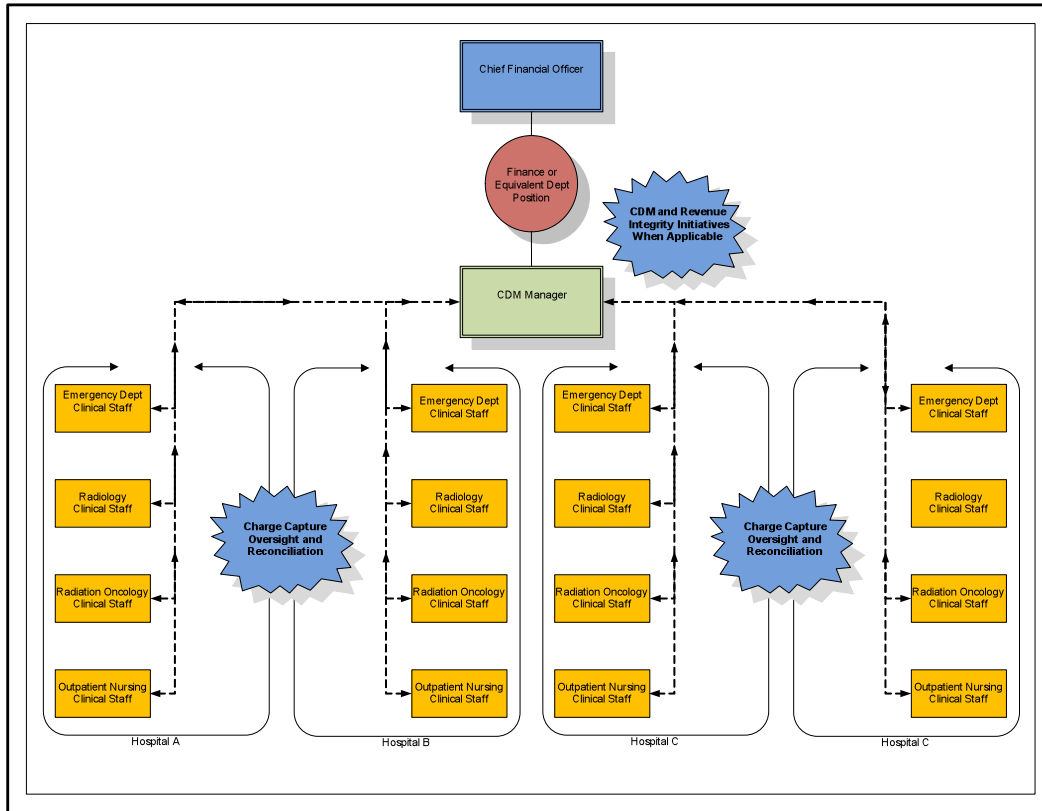


Figure 2

## How do Hospitals Leverage Effective and Compliant Charge Capture under Either Model?

Even though there are drawbacks and inefficiencies in the decentralized and centralized business models, improving the charge capture process is possible

Even though there are drawbacks to the decentralized model, improving the management of the charge capture process is not impossible. Many organizations have found that successful implementation of a charge capture solution resolves many of these issues. An effective charge capture software product will provide a solution to both the centralized model as well as the decentralized model.

In the case of the centralized model, a charge capture tool would leverage the Revenue Management support staff to more efficiently and holistically manage the charge capture process. Results can be trended and utilized to prepare clinical education if applicable. In the decentralized model, efficient charge capture is solely dependent on clinical participation. A charge capture software solution should provide a medium by which clinical staff can clearly understand governmental and charge capture billing guidelines relative to the day-to-day

charging and charge reconciliation process. In this scenario, addressing inappropriate or missing charges prior to billing is of the utmost importance.

By prospectively addressing all billing issues, whether related to missing charges, unstated procedures, inaccurate and non-compliant charging and National Correct Coding Initiatives, hospitals can capture additional revenue, increase operational efficiency, remain compliant, and significantly improve claim turn-around, resulting in immediate revenue enhancement and improved profit margins. An effective charge capture software solution should address all of the following charge capture issues:

- Prospective and retrospective identification of missing charges on bills with a workflow process for clinical or support staff to correct these opportunities. This should include a method by which both gross and net impact is calculated for added, modified, or deleted charges. The hospital should be provided the ability to modify these edits due to local or regional billing differences based on payer or patient type.
- Identification of Medicare National Correct Coding Initiative (NCCI) issues between services represented on the bill both prospective and retrospective with clinical explanation to support clinician transparency in understanding these edits. The hospital should have the opportunity to choose whether these edits are applied to all payers or just Medicare. These edits include:
  - Mutually exclusive
  - Allowable with a modifier
- Comparative analysis of ICD-9 procedure assigned by HIM to CPT codes on the bill. This is incredibly helpful to both identify potential coding opportunities as well as missing charges.
- Recognition of pricing opportunities at the bill item level in order to enable clinical or support staff to identify those clinical services, whether time-based or hard-coded in the CDM, that are priced less than Medicare APC (using payment rate as a proxy for cost).
- Capabilities to identify both adult and pediatric minimum and maximum pharmaceutical dosage variance. Where the dosage exceeds either the established minimum or maximum daily dosage, the bill is assigned to a workflow for a clinician or other analyst to review.
- The ability for outpatient Medicare medically unlikely edits to be reviewed by clinical staff. This would include an explanation of the Medicare edit regarding maximum established units by procedure in an effort to provide a mechanism by which clinical or support staff can correct these errors.
- A method by which daily department charges and late charges can be monitored. By benchmarking and trending both daily charges and late charges by department, hospitals are alerted to variances. Reporting capability should be available to the hospital that identifies where a single line on the bill has exceeded an established threshold. This threshold can vary by department, but this type of reporting capability contributes to successful management of patient overcharges.

- By Medicare definition, there are services that should only be provided to Medicare beneficiaries on an inpatient basis. An effective charge capture tool should identify these services when provided on a Medicare outpatient.
- In addition to these, a charge capture product should also provide the user the capability to create custom edits or “rules.” These “rules” should drive the user work lists to promote successful management of bills, either prospective (before the bill drops) or retrospective (from an audit perspective- after the bill drops to the payer).

## **Conclusion**

Comprehensive and compliant charge capture is a necessary key to surviving the trend of hospital payment cuts and strict regulations. No matter what revenue management approach is employed by a hospital organization, the use of technology will greatly increase the effectiveness of the process (and the resources necessary to complete the process), improve revenue recognition and expedite cash flow. Charge capture technology facilitates a sense of responsibility within the clinical area and provides a realistic methodology for charge capture management. This technology should offer immediate ROI and increase the efficiency of charge capture operations.

## **About the authors**

Jennifer Wexler, BSAS, RT(R)

Ms. Wexler is a health care professional with extensive knowledge related to hospital charge capture methodologies, correct coding, and analysis of claim, revenue management and CDM data. She was a thought leader in the formation of one of the first hospital Revenue Integrity departments nationally in response to changing outpatient regulatory environment and payer reimbursement cut-backs.

Her clinical experience includes registration by ARRT (American Registry of Radiologic Technologists) with experience in interventional radiology as well as experience in evaluating and implementing major inventory and charge capture systems in the radiology and cardiology areas within major hospital systems. As a consultant, Ms. Wexler has collaborated with large health organizations in a variety of revenue cycle strategic projects.

Kelly Bucci, BSBA, RHIT

Ms. Bucci is an accomplished visionary with experience in the health care consulting arena with a strategic focus on health care revenue cycle operations and management, coding,

compliance, charge capture, pricing and payer reimbursement for both large, academic medical centers and small community hospitals.

While with a big 4 firm, Ms. Bucci demonstrated a stellar track record for significantly increasing health care provider net revenues, redefining pricing strategies and charge capture standardization to effectively compete with national and peer group leading practices.